

ADVANCE DIRECTIVE

PART A **APPOINTMENT OF HEALTH CARE AGENT**

(If you want to appoint an agent to make health care decisions for you, fill out this form and cross through any items in the form that you do not want to apply. Cross through this whole page of the form if you do not want to appoint a health care agent)

1. I, _____ residing at
(Full Name of Declarant)

(Address of Declarant)

appoint the following individual as my agent to make health care decisions for me:

(Full Name, Address and Telephone Number of Agent)

(Optional) If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:

(Full Name, Address and Telephone Number of Back-up Agent)

2. My agent has full power and authority to make health care decisions for me, including the power to:

- A. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;
- B. Employ and discharge my health care providers;
- C. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and
- D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures,

3. The authority of my agent is subject to the following provisions and limitations:

4. If I am pregnant, my agent shall follow these specific instructions:

5. My agent's authority becomes operative *(initial only the one option that you want)*:

_____ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care; **or**

_____ When this document is signed.

6. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

7. My agent shall not be liable for the costs of care based solely on this authorization.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

(Date)

(Signature of Declarant)

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual.

(Name of Witness - Printed)

(Name of Witness - Printed)

(Witness Signature)

(Witness Signature)

(Address)

(Address)

(Signatures and Addresses of Two Witnesses Required)

ADVANCE DIRECTIVE

PART B **HEALTH CARE INSTRUCTIONS**

(If you want to give instructions about your future health care, fill out this form and place your initials in front of any instructions that you want carried out. Place an "X" in front of any instructions in the form that you do not want carried out.)

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below.

1. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

2. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

4. _____ I direct that, no matter what my condition, medication to relieve pain and suffering not be given to me if the medication would shorten my remaining life.

5. _____ I direct that, no matter what my condition, I be given all available medical treatment in accordance with accepted health care standards.
6. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:
- _____
- _____
- _____
7. I direct (in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care. Write "None" if there are no additional instructions):

By signing below, I indicate that I am emotionally and mentally competent to make this Advance Directive and that I understand the purpose and effect of this document.

(Date)

(Signature of Declarant)

The declarant signed or acknowledged signing these health-care instructions in my presence and, based upon my personal observation, appears to be a competent individual.

(Name of Witness - Printed)

(Name of Witness - Printed)

(Witness Signature)

(Witness Signature)

(Witness Address)

(Witness Address)

(Signatures and Addresses of Two Witnesses Required)

ORGAN DONATION ADDENDUM

(Note: If you want to be an organ donor, sign this form, have it witnessed and attach it to your Living Will or Advance directive.)

I direct that if I am brain dead, an anatomical gift be offered on my behalf to a patient in need of an organ transplant. If a transplant occurs, I want artificial heart / lung support devices to be continued on my behalf only until organ or tissue suitability of the patient is confirmed and organ or tissue recovery has taken place.

By signing below, I indicate that I am emotionally and mentally competent to make this organ donation addendum and that I understand the purpose and effect of this document.

(Date)

(Signature of Declarant)

The declarant signed or acknowledged signing this organ donation addendum in my presence and based upon my personal observation appears to be a competent individual.

(Name of Witness – Printed)

(Name of Witness – Printed)

(Signature of Witness)

(Signature of Witness)